UNITED STATES MARINE CORPS
3D MARINE DIVISION (-) (REIN)
UNIT 35801
FPO AP 96602-5801

In reply refer to:
DivO 6320.3A
SURG

02 JUL 1998

DIVISION ORDER 6320.3A

From: Commanding General
To: Distribution List

Subj: MEDICAL QUALITY ASSESSMENT/QUALITY IMPROVEMENT (QA/QI PROGRAM

Ref: (a) OPNAVINST 6320.7
(b) BUMEDINST 6010.13
(c) BUMEDINST 6320.66B
(d) MARFORPAC P6320.3A

Encl: (1) Sample Appointment Letter for Division QA/QI Coordinator
(2) Sample Appointment Letter for QA/QI Committee Member
(3) Sample Appointment Letter for Regimental/Battalion QA/QI Coordinator
(4) Sample Format for Division QA/QI Summary Minutes
(5) Sample Format for Regimental/Battalion Monthly QA/QI Minutes
(6) Clinical Indicators/Aspects of Care
(7) Volume Indicator Tracking Sheet
(8) Issue Referral Report
(9) Occurrence Screen
(10) Patient Satisfaction Survey
(11) Outpatient Medical Record Review
(12) Clinical Performance Profile

1. Purpose. To establish policy, publish procedures, and assign responsibility for the Medical Quality Assessment and Quality Improvement process within the 3d Marine Division.

2. Cancellation. DivO 6320.3

3. Background. The Chief of Naval Operations and Commandant of the Marine Corps are committed to continuously improving the quality of medical and dental care provided to Department of the Navy beneficiaries. A Quality Assurance program was established in 1984 to standardize activities within Naval Medical Departments.

4. Summary of Revision. This revision contains a substantial number of changes and must be completely reviewed.

5. Goals. The goal of 3d Marine Division Medical QA/QI Program is to ensure that all health care provided is of high quality and to objectively assess the quality of care, identify any current problems, and at the same time seek opportunities for improvement.

6 3d Marine Division QA/QI Plan (Ten Step Process)

a Assign Responsibility (Step 1)

(1) Commanding General. The Commanding General, 3d Marine Division is the privileging authority for all 3d Marine Division medical providers and approves the command QA/QI plan. The Commanding General is responsible for establishing, maintaining, and supporting an ongoing QA/QI program, and resolving QA/QI related problems that cannot be addressed and resolved at lower levels.

(2) Division Surgeon

(a) Principal advisor to the Commanding General for medically related QA/QI issues.

(b) Serves as the Chairman of the 3d Marine Division QA/QI Committee.

(c) Has the responsibility for oversight and guidance of the QA/QI Program.

(d) Reviews and forwards the minutes of the QA/QI meetings to the Commanding General via the Chief of Staff with recommendations for final action on unresolved problems or issues.

(3 3d Marine Division QA/QI Coordinator

(a) Appointed by the Division Surgeon and is responsible for collection and coordination of QA/QI data (enclosure 1).

(b) Serves as a member of the 3d Marine Division QA/QI committee

(c) Assists battalion and regimental coordinators with their programs and resolving problems.

(d) Maintains on file all reports and documentation presented to the Division QA/QI committee.

(e) Initiates agenda items and submits minutes of the 3d Marine Division QA/QI meetings through the proper chain.

(f) Assists the Division QA/QI committee chairman in annual reappraisal of the Division QA/QI program.

(4 3d Marine Division QA/QI Committee

(a) Chairman. The Division Surgeon is the Chairman for the Division QA/QI Committee.

(b) Membership. Members shall be appointed by the Division Surgeon, as shown in enclosure (2). Committee consists of, but is not limited to, the following personnel:

1 Chairman.

2 All Division Medical Officers.

3 Environmental Health Officer

4 Division QA/QI Coordinator

5 Regimental and Battalion QA/QI coordinators.

6 Division Patient Contact Representative.

(c Responsibilities

1 Meets quarterly to discuss any issues or problem that relate to delivery of care within the 3d Marine Division.

2 Serves in an oversight and advisory role and performs data analysis to identify opportunities for improvement.

3 Reports to the Commanding General, 3d Marine Division.

4 Ensures information from QA/QI programs flows back to aid stations.

5 Identifies, assesses, directs, and monitors any corrective actions taken involving standards of care, record keeping, or any other aspects of medical care.

6 Reappraises the effectiveness of the QA/QI program bi-annually.

(5) Regimental/Battalion QA/QI Committee

(a) The regimental/battalion surgeon is the chairman and is responsible for coordination and integration of the QA/QI program within his unit.

(b) Meets monthly with the respective surgeons to discuss problems/issues identified or related to quality medical care.

(c) Submits minutes to Division Surgeon via respective commanding officers.

(d) Appoints regimental/battalion QA/QI coordinator enclosure 3).

(6) Regimental/Battalion QA/QI Coordinator

(a) Is knowledgeable of the QA/QI process and current requirements.

(b) Orients new staff to the QA/QI program

(c) Assists the regimental/battalion committee in coordinating, planning, and conducting monthly meetings.

(d) Prepares monthly QA/QI minutes to be submitted to the Division Surgeon via respective commanding officers as shown in enclosures (4) through (6).

b Delineate the Scope of Care (Step 2)

(1 General health care.

(2) Immunizations

3) Minor surgery

(4) Musculoskeletal injuries

(5) Pharmacy.

Physical examinations.

(7) Preventive medicine.

(8) Sickcall

(9) Health promotion and education.

(10) Medical coverage for operational and recreational activities.

c. Identify the Important Aspects of Care (Step 3)

The following important aspects of care to be assessed within organizations of the 3d Marine Division:

Access to care.

Emergency care

Infection control

(4) Medical records review

(5) Use of medications.

(6) Customer satisfaction

7) Patient safety.

(8) Education of patients

d. Identify Indicators (Step 4)

(1) Each aid station will monitor a minimum of two clinical indicators based on one or more important aspects of care and should be ongoing at all times. Initially, results will be documented in the aid station's monthly QA/QI report/minutes on a monthly basis and, thereafter, at least on a quarterly basis, utilizing the format in enclosure (5). The Division Surgeon will select one clinical situation and one drug on a quarterly basis for monitoring.

(2) As shown in enclosure (6), clinical indicators are developed to routinely monitor important aspects of care. A clinical indicator is a quantitative measure that can be used as a guide to monitor and evaluate the quality of patient care and support service activities. Indicators are of two general types: sentinel and rate-based. A "sentinel" event is a serious or undesirable, low frequency and often avoidable process or outcome. A "rate-based" indicator usually measures an event for which a certain rate is acceptable. As data is collected over a number of cases, there can be a "threshold" established so as to trigger a more in-depth review. The indicator may be an "outcome" or "process" indicator.

e. Establish Thresholds for Evaluation (Step 5)

(1) As previously mentioned, when data is collected there can be a "threshold" established to trigger a more in-depth review. A threshold is a yardstick or gauge against which the quality and appropriateness of an aspect of care (as defined by an indicator) can be measured. Thresholds can be developed through review of the literature, national standards, statistical limits, patient needs, or a review of 3d Marine Division policies, procedures, and experience. Medical officers may also propose thresholds for the concurrence by their commanding officer and subsequent implementation on a individual unit or division wide basis by the QA/QI committee. Thresholds will be reevaluated for possible re-establishment on an annual basis.

(2) Thresholds are not absolute standards of care. They are tools for identifying practices or processes that should be subjected to closer scrutiny by the clinical staff. Other mechanisms that may prompt intensive evaluation include:

(a) Desire to improve overall performance

(b) Benchmarking (comparing one's performance with others)

(c) Staff observations/recommendations

(d) Evaluation of customer needs, satisfaction, or dissatisfaction.

(e) Patterns and/or trends in indicator data

f. Collect and Organize Data (Step 6)

(1) Each aid station will have a designated QA/QI coordinator responsible for coordinating monthly data collection and reporting in minute format. Sources of data include QA/QI database, clinic logs, patient medical records survey, radiology and laboratory reports, medication prescriptions, minutes, other reports, or direct observation of staff or patients.

(2) Each QA/QI coordinator will plan data collection methods for each indicator selected. The following questions will be recorded prior to collection of data:

Who will collect and organize data?

Will collection be prospective or retrospective?

What is the frequency of review?

(3) Data collection will include medical record and minor surgery procedure review data based upon preestablished criteria. All minor surgical procedures will be reviewed. In addition, a minimum of five medical records per week, per provider, will be reviewed. A minimum of 20 percent of health records must be reviewed for provider with preceptor. One hundred percent of all corpsman sick call entries will be reviewed by the respective regimental, battalion surgeon, or senior medical department representative.

g Evaluate Care/Service Against Thresholds (Step 7)

(1) Aid stations will hold monthly meetings to discuss the results of their monitoring and evaluation activities. They will decide what needs to be studied in more detail and they will set priorities for further review with guidance from the Division Surgeon

2) Two major ways care/services are evaluated

Indicator Assessment

1 When the cumulative data reaches or exceeds the predetermined threshold, the staff will evaluate the data provided to determine whether an opportunity for improvement or a problem exists.

2 When the cumulative review data does not exceed the threshold over a period of time, reevaluate the predetermined threshold to determine if it is appropriate for the aid station. If it is appropriate, then consider changing to a new clinical indicator with a special follow-up assessment of the old clinical indicator in 3-6 months to insure continued satisfactory performance. Another approach would be to make the existing threshold more stringent. For example: If a one hour patient waiting time threshold was consistently being met, then consider changing the threshold to 30 or 45 minutes.

Peer Review

(1) Peer review is a fair evaluation of health care practices by those who have training and experience similar to, but not necessarily the same, specialty of the individual providing care

(2) The purpose is to improve practices, reduce morbidity and mortality, and to provide the basis for appointments reappointments, and privileging of staff.

(3) Within 3d Marine Division, clinical care review evaluates the outcome of individual care.

h. Take Actions to Improve Care/Service (Step 8)

(1) Aid stations will indicate actions to achieve improvement in care or services once an opportunity for improvement has been identified. Action items include:

System Issues

1 Adjust communication channels

2 Adjust staffing.

3 Change forms

4 Establish/improve monitoring.

Indicator Assessment

1 When the cumulative data reaches or exceeds the predetermined threshold, the staff will evaluate the data provided to determine whether an opportunity for improvement or a problem exists.

2 Provide continuing medical education

(c Behavior Issues

1 Provide formal/informal counseling.

2 Change assignment.

3 Disciplinary action.

(2) The item status report will be the tool used in the monthly QA/QI minutes to identify issues, track the progress of action taken to improve the process, and to document improvements made in care or services. An attendance matrix will be maintained to document attendance of pertinent personnel.

Assess Actions and Document Improvement (Step 9)

(1) If actions taken are effective, continued assessment of these actions will take place in an attempt to maintain improvement. The results of continued monitoring and evaluations are carefully documented to provide a record of the efficacy of the process.

(2) Once success has been achieved and further efforts gain only marginal improvement, important aspects of care and indicators will be reevaluated. Important aspects of care or service will be reviewed regularly.

j. Communicate Relevant Information Division-wide (Step 10)

(1) In an effort to improve care, minimize duplication of effort, and ensure that relevant findings are used in the periodic reappraisal of providers, information derived from monitoring and evaluation is shared among aid stations and through the chain of command. 3d Marine Division QA/QI Plan information is shared by the following methods:

QA/QI reports/minutes.

QA/QI biannual reviews

(c) QA/QI training for QA/QI representative/committee chairman.

Group and one-on-one QA/QI consultations

QA/QI memoranda.

(2) QA/QI Reports: A monthly QA/QI committee meeting, chaired by the regimental/battalion surgeon, will be held during the first week of each month at the respective aid stations.

(3) A Division QA/QI meeting, chaired by the Division Surgeon, will be held quarterly at the 3d Marine Division Headquarters. Summary of minutes will be routed as follows:

3d Marine Division QA/QI Coordinator.

3d Marine Division Surgeon.

3d Marine Division Chief of Staff

3d Marine Division Commanding General

(4) Each aid station QA/QI coordinator will be responsible for monthly minutes formulation guided by the committee chairman and submitted via the reporting chain of command. Enclosure (5) is a common format for content of Regimental/Battalion QA/QI reports. All reports are to arrive at the Division Surgeon's Office no later than five working days following the meeting. Minutes will be routed as follows:

Battalion or Regimental QA/QI coordinator

Battalion or Regimental Surgeon

Commanding Officer of respective aid station

(d) Regimental Commanding Officer if unit is on Unit Deployment to Okinawa or if battalion/regimental relationship exists.

3d Marine Division QA/QI Coordinator.

(f) 3d Marine Division Surgeon.

7 Terminology/Elements

a. The Comments/findings, Recommendation, Actions, Follow-up (CRAF) format will be used to communicate the thought process as follows:

(1 C - Comments/findings

(2) R - Recommendations

(3) A - Actions

4) F - Follow-up

b. Findings

(1) Although not part of the CRAF acronym, each presentation of the results of monitoring and evaluation should begin with a summary statement of the findings. Findings are the data about the aid station performance. The following questions should be answered by the "Findings" section:

What was monitored?

What was the monitoring time period?

(c) What was the total volume of activity under review as stated in enclosure (7) (e.g., number of patients, number of procedures, number of encounters, etc)?

(d) What volume of activity was monitored (e.g., sample size)?

(e) What was the performance, based on the percentage of activity, meeting the indicators compared to the total volume of activity monitored?

(f) Is there a significant variance between the aid station's performance and a predetermined desired level of performance?

(2) There may be a reference to control charts, graphs, trend charts, or other tools for data display used by the committees to review the findings. These tools should be attached to the minutes.

c. Conclusion. After the findings are presented, the conclusion represents the QA/QI committee's evaluation and analysis of the data. The conclusion is the QA/QI committee's diagnosis and gives an explanation or reason for the recommendation and action to follow. Key points to cover in the "conclusion" section are outlined with the following questions:

(1) Does the significant variance represent a pattern or trend in care or outcome, or a variance due to special cause?

(2) Is there opportunity for improvement?

(3) If there is an opportunity to improve, what is the root cause of the problem (e.g., systems, knowledge or skills, behavior, or root cause is unclear)?

(4) If there is an opportunity to improve, does the scope of the problem (e.g., level of impact) necessitate immediate action?

(5) If an opportunity to improve or a problem is not evident, is the monitoring tool appropriately constructed (e.g., aspect of care, indicators, sampling, and data collection techniques/frequency are valid)?

d. Recommendations. The recommendation represents a general description of what will be done to improve. The recommendation should be appropriate to the command's or committee's authority to act. The recommendation should be based on the priority of the opportunity, the assessment of the root cause of the problem, the complexity of the processes involved, and the need for quick action as determined by the severity of the problem. The command or committee should have a goal for improving outcomes and/or efficiency. The following questions should be answered in the recommendation section:

(1) If the conclusion is that there is an opportunity to improve, but it is not within the scope of the command's or committee's authority to take direct action, is referral to higher authority, committee, or supporting medical treatment facility (MTF) recommended as outlined in enclosure (8).

(2) If the conclusion is that there is an opportunity to improve, and it is within the command's or committee's authority to take direct action, and the root cause is clear, the processes involved are not complex, and quick action is desirable, is action appropriate to the root cause recommended as follows:

(a) Improve communications, add staffing or technology, revise policies and procedures, improve on interdisciplinary coordination/integration.

(b) Improve knowledge or skill - provide classes, inservices, seminars, reference resources, proctoring, and enhanced orientation

(3) If the conclusion is that an opportunity to improve is not evident, but that the monitoring tool is not appropriately constructed to accurately measure performance/outcomes, are changes to the monitoring tool recommended.

(4) If the conclusion is that an opportunity to improve is not evident and that the monitoring tool is appropriately constructed, no changes should be recommended.

e. Action

(1) The action plan is a specific description of what will be done, including assignment of responsibility and time frame for completion. The action plan may include the testing of a strategy for improvement on a limited basis prior to full implementation. The action plan should answer the following questions:

(a) What specifically will be done?

(b) What is expected to change (e.g., what is the goal)?

(c) Who is responsible for implementing action?

(d) When is the action expected?

(2) The action plan should match the scope of the problem (e.g., if only one individual is causing the problem, the action should target that individual versus the whole staff).

f. Follow-up

(1) The follow-up represents the interval of time in which the effectiveness of the action taken is assessed.

This assessment is accomplished either by initiating monitoring or continuing ongoing monitoring of the care and reporting back to the Division Surgeon or committee.

(2) The following questions should be answered in the follow-up section.

(a) How will the effectiveness of the action taken be assessed (e.g., either new or ongoing monitoring of care)?

(b) When will the new data be presented to the command or committee?

g. CRAF can be viewed as though the minutes were a medical record

(1 Findings would be the lab, x-ray, and electrodiagnostic results

(2) Conclusion would be the working diagnosis.

(3) Recommendation would be the general treatment plan including social consultation.

(4) Actions would be the doctor's orders

(5) Follow-up would be the plans for monitoring the patient's condition, including repeating lab, x-ray, and electrodiagnostic testing, and tracking the patient's progress all the way through to discharge.

8. Annual Assessments

a. Annual evaluation of the QA/QI plan/program. The Division Surgeon will be responsible for reviewing this plan/program annually in December.

b. Credentials/Certification Review. Credentials/Certification review of aid station providers is performed biannually by the Division Surgeon. Activities that provide information for this review include but are not limited to:

Clinical activity file

Direct observation.

Medical record review

Occurrence screens

Medical staff monitors

Risk management activities

Patient complaint and satisfaction data

9. Management Variance Report (MVR). Management variances are those incidences that occur within a treatment facility but are not related to the provision of care, such as slips and falls, theft, etc.

a The following events will initiate a MVR

(1) Problems with equipment or supplies.

(2) Fire.

(3) Altercation/abuse

(4) Complaints.

(5) Patient refusal of treatment or leaving "against medical advice" (A.M.A.).

b. The MVR must answer the following questions

(1 What happened?

(2) When did it happen?

(3 Where did it happen?

Who was involved?

What caused the event?

(6) What steps, if any, should be taken to prevent a recurrence of this event?

c. The regimental/battalion QA/QI committee will investigate all MVRs and either formulate action or forward to the respective command and Division QA/QI committee for further evaluation.

d. All MVRs will be forwarded to the Division QA/QI committee chairman for review and signature.

10. Occurrence Screening

a. Occurrence screening is a QA/QI tool that focuses on the quality of care given to a patient as documented in the medical record. Occurrence screening is established to assess appropriateness and completeness of care given.

(1) The following events will initiate an occurrence screen

(a) Morbidity or mortality when occurring under the cognizance of Navy medicine.

(b) Congressional inquiry.

(c Medication error/drug reaction

(d) Significant trends noted in provider's performance profile

The following might initiate an occurrence screening

(a) Inappropriate medical record entries

(b) Prolonged patient waiting time

(c Lack of reasonable follow-up/non-compliance of follow-up

(d) Repeated visits for medication, especially without a medical officer's evaluation.

(e) Timeliness of x-ray/lab requests

(f) Timeliness of return of consultation reports

(g) Procedural errors in treatment

Occurrence screening MUST answer the following

(a) What happened?

(b) When did it happen?

(c) Where did it happen?

(d) Who was involved?

(e Was adequate care rendered, and if not, where did it cease?

(f) What is the expected outcome?

(g) Will the patient have any debilitating residuals?

(h) What could have been done to achieve a better outcome?

(i) What steps, if any, should be taken to prevent a recurrence of this situation?

b. Regimental/battalion QA/QI committee will determine the categories of occurrences and will report any findings greater than Category II (encl (9)) to the Division QA/QI committee.

c. All occurrence screen reports, regardless of category level,

will be forwarded to the Division QA/QI committee chairman for signature.

d. Information concerning the numbers and types of occurrence screens will be included in the regimental QA/QI minutes of their meetings.

e. Occurrence screen reports are QA/QI documents and as such will not be duplicated nor retained at the unit level. After these documents are logged, they will be forwarded to the next higher level for action. Upon completion, they will be forwarded to the Division QA/QI coordinator for filing.

11 Division Patient Contact Representative Program

a. The Division Patient Contact Representative (PCR) Program is an integral part of providing total quality medical care throughout the Division.

b. The PCR will be the Senior Medical Department Representative (SMDR) within each Division organization.

c. Each patient contact will be reported utilizing the contact information sheet.

d. Each PCR will be a member of the organization's QA/QI committee and will report contacts and findings at the QA/QI committee meeting.

e. The Division Patient Contact Representative Program Manager will be a senior enlisted member appointed by the Division Surgeon and be a member of the Division QA/QI committee. Patient Satisfaction Survey Reports for any unit will be submitted semi-annually to the Division QA/QI committee.

12. Patient Satisfaction Survey Reports

a. Patient Satisfaction Survey Reports will be completed by the unit Patient Contact Representative (PCR) as outlined in encl. (10).

b. The collection of patient satisfaction data is the responsibility of the unit PCR.

c. Patients will be afforded the opportunity to comment on their treatment in all Division medical units. This survey will be made available to all patients when the medical unit is in operation.

d. All patient complaints, whether received verbally, or as part of the collection of patient satisfaction surveys, will be referred to the unit PCR for validation. Validated complaints, as well as compliments received, will be part of the monthly QA/QI report.

13. Medical Officer Screening Health Records

a. All hospital corpsmen progress note entries in medical records shall be in standard "Subjective, Objective, Assessment, and Plan" (SOAP) format. The administrative portion of selected medical record entries shall be reviewed by the QA/QI coordinator per encl. (11). The medical content of all entries involving standards of care shall be reviewed and countersigned by a medical officer. His/her signature indicates that she/he approves of the care rendered and assumes full responsibility for that care.

b. The numbers of record entries reviewed shall be recorded along the numbers of entries which requires corrective action.

c. The medical officer shall determine which improper entries constitute significant deviations from standards of care. These occurrences will be entered into the provider's Clinical Performance Profile per encl. (12).

d. Significant deviations and occurrences will be reviewed by the regimental/battalion QA/QI committee with a summary sent to the Division QA/QI committee.

e. A temporary record of all improper entries will be maintained by battalion QA/QI coordinators as a yardstick to measure trends in an individual provider's standard of performance. This will trigger corrective action and be utilized as a tool for improvement.

13. Annual Reports. Management information reports on QA/QI activities within 3d Marine Division are due to the Bureau of Medicine and Surgery via Commanding General, III Marine Expeditionary Force and Commander, U.S. Marine Corps Forces Pacific, 15th of January each year.

L. M. SUPKO
Chief of Staff

DISTRIBUTION: A/D

Sample Appointment Letter for Division QA/QI Coordinator

Command Letter Head

6320
SSIC
DATE

From: Commanding General, 3d Marine Division
To: Rate, Name, SSN, USN/Desig

Subj: APPOINTMENT AS DIVISION QUALITY ASSURANCE/QUALITY IMPROVEMENT (QA/QI) COORDINATOR

Ref: (a) DivO 6320.3A

1. You are hereby assigned to the position of Division Quality Assurance and Quality Improvement Coordinator. You will carry out your duties as prescribed in the reference.

2. This assignment will terminate upon assignment to another position or transfer from this command.

(Division Surgeon's Signature)
By direction

Copy to:
File

ENCLOSURE (1

DivO 6320.3A
02 JUL 2008

Sample Appointment Letter for QA/QI Committee Member

Command Letter Head

6320
SSIC
DATE

From: Commanding General, 3d Marine Division
To: Rate, Name, USN, SSN/Desig

Subj: APPOINTMENT AS DIVISION QUALITY ASSURANCE/QUALITY IMPROVEMENT COMMITTEE MEMBER

Ref: (a) BUMEDINST 6010.13
(b) DivO 6320.2

1. Per references (a) and (b), you are hereby appointed as a member of the Division Quality Assurance/Quality Improvement Committee for 3d Marine Division.

2. You are directed to familiarize yourself with the references and the 3d Marine Division program.

3. This appointment will terminate upon assignment to another position or transfer from this command.

_____
Chief of Staff

Copy to:
File

ENCLOSURE (2)

DivO 6320.3A

02 JUL

Sample Appointment Letter for Regimental/Battalion QA/QI Coordinator

Unit Letter Head

6320
SSIC
DATE

From: Regimental/Battalion Surgeon, Unit
To: Division Surgeon, 3d Marine Division
Via: Commanding Officer, Unit

Subj: APPOINTMENT AS REGIMENTAL/BATTALION QUALITY ASSURANCE/QUALITY IMPROVEMENT (QA/QI) COORDINATOR

Ref: (a) DivO 6320.3A

1. You are hereby assigned to the position of Regimental/Battalion Quality Assurance and Quality Improvement Coordinator. You will carry out your duties as prescribed in the reference.

2. This assignment will terminate upon assignment to another position or transfer from this Regiment/Battalion.

(Regimental/Battalion Surgeon Signature)
Regimental/Battalion Surgeon

Copy to:
Division QA/QI Coordinator
File

ENCLOSURE (3)

Sample Format for Division QA/QI Quarterly Minutes
COMMAND ADDRESS

6320
SURG
DATE

From: Chairman, Division QA/QI Committee
To: Commanding General, 3d Marine Division
Via: Chief of Staff, 3d Marine Division

Subj: SUMMARY OF THE MEDICAL QUALITY ASSURANCE/QUALITY IMPROVEMENT (QA/QI) COMMITTEE MEETING

Ref: (a) DivO 6320.3A

1. Per reference (a), the Medical QA/QI Committee held its 2nd quarterly meeting for CY 97 on 28 May 1997 at 1300 in the G-1 Navy Conference Room.

2. The following items were discussed:

a. Reporting of Occurrence Screen. Proper handling and reporting in a confidential manner was emphasized.

b. Clinical Activity Files. The proper use of the clinical activity file was discussed. Data on clinical and administrative activities will be reported using the approved transmittal to the reference.

3. With no further business to discuss, the meeting was adjourned at 1400.

DIVISION SURGEON SIGNATURE

ENCLOSURE (4)

Sample Format for Regimental/Battalion QA/QI Monthly Minutes

UNIT ADDRESS

6320
RAS/BAS
(Date)

From: Regimental/Battalion Surgeon, Unit
To: Division Surgeon, 3d Marine Division
Via: Commanding Officer, Unit

Subj: MEDICAL QUALITY ASSURANCE/QUALITY IMPROVEMENT (QA/QI) MINUTES FOR THE MONTH OF _____
(month/year)

a) DivO 6320.3A

1. The QA/QI meeting of the Unit Aid Station was held on 29 June 1997 at 1300 to assess the quality and appropriateness of patient care and services.

2. Education and Training Requirements. The following topics were covered during inservice training:

a Writing Correspondence.

b. Spell Check.

c. How to use computers.

d Common Sense

3 Old Business

a. TARGETED REVIEWS

(1 Psychiatric Assessment (97-08-01

(a) Comments: One patient seen with diagnosis in psychiatric disorder. Criteria for evaluation meets as per Division Surgeon standards.

(b) Recommendation: Referred to USNH Psychitric Clinic further evaluation and monitor.

(c Action: All Health Care Provider

(d) Follow-up: Medical Officer

ENCLOSURE (5)

DivO 6320.3A
02 JUL 1998

Subj: MEDICAL QUALITY ASSURANCE/QUALITY IMPROVEMENT (QA/QI) MINUTES FOR THE MONTH OF _____
(month/year)

4 New Business:

a TARGETED REVIEWS

(1 Acute Low Back Pain (97-08-05)

(a) Comments: Nine patient identfied with acute low back pain. Meets the criteria for evaluation as per Division Surgeon standards.

(b) Recommendations: Educate Marines on safety and proper lifting technique.

(c Action: All Health Care Providers

(d) Follow-up: Medical Officers

5. Administrative Remarks:

a. Patient Satisfaction Survey: Twenty forms were distributed during sickcall hours for the month of June 1997. Fifteen were positve comments and five were complaints concenrning prolonged waiting time from 30 minutes to one hour.

6. With no further business to discuss, the meeting was adjourned at 1355. The next QA/QI committee meeting will b eheld on 29 July 1997.

I M. SURGEON

Enclosure (5)

Clinical Indicators/Aspects of Care

IMPORTANT ASPECT OF CARE:		RATIONALE:			
CLINICAL INDICATOR	% THRESHOLD	% COMPLIANCE			FINDING/DATA
	95%	NOV	DEC	JAN	
1. #PPDs Read in 72 Hours					
2. Total PPDs Given					
CONCLUSIONS: (Evaluate care or process based on evaluation of findings)					
RECOMMENDATIONS:					
ACTIONS TAKEN TO IMPROVE CARE: (Policy change, classes, educational link, data collection refinement, communication between Aid Stations)					
IMPROVEMENTS:					
FOLLOW-UP: (How the progress of this indicator will be tracked)					
SURGEONS COMMENTS:					

ENCLOSURE (6)

Volume Indicators Tracking Sheet for FY**

Volume Indicators	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Outpatient Visits												
Rx Refills												
Immunizations												
Minor Surgery Cases												
Physical Exams												
PAP Smears												
Sickcall Patients												
Findings:			Recommendations:				Action:			Follow-up:		

ENCLOSURE (7)

ISSUE REFERRAL REPORT

Date of Referral:

From:
To:

1. Issue

2. Please return a copy of this form to:_____

Item Status Number has been assigned to this issue

Signature

ACKNOWLEDGEMENT OF REFERRAL

Date:

From
To:

RESPONSE

1 Actions considered or taken:

2. Recommendation for continuous monitoring:

Signature

Copy to:
Referring Aid Station
Div QA/QI Coordinator

OCCURRENCE SCREEN

An event identified by this form does not automatically imply errors or quality of care compromises. Completion of this form may trigger a more in-depth review. Accurate and timely reporting helps improve the current system, prevents further similar incidents and can be used as an educational tool.

SECTION I

This section will be completed by the health care provider initiating the form.

EVENT: _____

UNIT: _____ DATE OF EVENT

FORM COMPLETED BY: _____ DATE: _____
SUMMARY OF EVENT: _____
_____
_____
_____

ROUTE TO REGIMENTAL OR BATTALION SURGEON

SECTION II

This section will be completed by the Regimental, Battalion Surgeon or designated Senior Medical Department Representative. The provider completing this form will determine the level of occurrence and proper routing.

CATEGORY I: ☐ Predictable occurrence within standards of care

CATEGORY II: ☐ Unpredictable occurrence within standards of care.

CATEGORY III: ☐ Occurrence related to marginal deviation from standards of care.

CATEGORY IV: ☐ Occurrence related to significant deviation from normal standards of care.

CONCLUSION _____

RECOMMENDATIONS: _____

ACTIONS: _____

ENCLOSURE (9)

FOLLOW UP: PEER REVIEW/FINDINGS WILL BE REPORTED IN MONTHLY QI MINUTES FOR THE MONTH OF: _____.

_____
REGIMENTAL/BATTALION SURGEON'S
SIGNATURE/DATE

Forwarded as needed for additional review and comment

TO: _____

CONCLUSION: _____

RECOMMENDATIONS: _____

ACTIONS: _____

FOLLOW UP: PEER REVIEW/FINDINGS WILL BE REPORTED IN MONTHLY QI MINUTES FOR THE MONTH OF: _____.

_____
SIGNATURE/DATE

RETURN TO ORIGINATOR FOR TRACKING, TRENDING, AND REVIEW.

ENCLOSURE (9

Patient Satisfaction Survey
(Unit)

1. Approximately how many times have you been to the RAS/BAS in the last six months? ____

2 How long did you wait to be seen at the RAS/BAS? _____
Was this longer than anticipated? YES NO

3. If there were delays did the staff explain the reason for the delays
YES NO

4. Do you feel that sufficient care was provided? YES NO

	EXCELLENT	VERY GOOD	GOOD	FAIR	POOR
5 Corpsmen: Were the corpsmen courteous and helpful?	5	4	3	2	1
Did the corpsmen answer your questions and keep you informed?	5	4	3	2	1
Did the corpsmen take care of your needs quickly?	5	4	3	2	1
6. Doctor: Was the doctor courteous and helpful?	5	4	3	2	1
Did the doctor answer your questions and keep you informed?	5	4	3	2	
Did the doctor explain all tests or treatment?	5	4	3	2	1
7 Overall skill and professionalism of the staff that cared for you?	5	4	3	2	1
8. Aid Station: Cleanliness and comfort of the aid station?	5	4	3	2	1
Did the staff explain to you what to expect and how to care for yourself after discharge? Corpsman:	5	4	3	2	1
Doctor:	5	4	3	2	1

Did you understand your treatment? YES NO

9 What suggestions do you have for improving the aid station:

_____
_____
_____
_____
_____

10. Any comments, complaints, or suggestions are appreciated

_____
_____
_____
_____
_____

UNIT (REQUIRED)	DATE (REQUIRED)	PRINTED NAME & RANK (OPTIONAL)	SIGNATURE (OPTIONAL)
_____	_____	_____	_____

ENCLOSURE (10)

DivO 6320.3A
02 JUL 1998

OUTPATIENT MEDICAL RECORD REVIEW
3D MARINE DIVISION

Provider _____ Reviewer _____

Name of Patient _____ Date of Review _____

Last 4 SSN of Patient _____ Date of Entry _____

To be completed by designated QA/QI Corpsman	Threshold	Yes	No	N/A
1. Complete patient indentification box	100%			
2. Full 11 digit SSN	100%			
3. Phone numbers	100%			
4. Notation where record is maintained	100%			
5. Vital signs	100%			
6. Provider's name, SSN and signature	100%			
7. Chronic conditions reported on problem summary list	100%			
8. Allergy history on problem summary list	100%			
9. Allergies and medications listed	100%			
To be completed by medical officer	Threshold	Yes	No	N/A
10. History adequate	100%			
11. Physical exam appropriate	100%			
12. Lab and x-ray studies, initialled, dated, acted upon by M.O.	100%			
13. Appropriate assessment	100%			
14. Appropriate treatment	100%			
15. Appropriate consultation	100%			

Comments (Required for negative responses)

ENCLOSURE (11